Child Fatality Review #08-18
Region 5
Kitsap County

This seven-month-old Caucasian female died from positional asphyxiation.

Case Overview

On April 24, 2008 a Kitsap County Sheriff contacted Child Protective Services (CPS) intake to report the unexpected death of this seven-month-old infant. Law enforcement reported the deceased child's father called 911 after finding her blue, cold to the touch, and not breathing. Resuscitation efforts were attempted by adults in the home until emergency personnel arrived. The infant's mother said she fed the infant with a bottle and laid her down for a nap on her back. Approximately 45 minutes later she picked her up to change her diaper and found her cold and stiff. There were two pillows at the head of the mattress and the infant was face down in between the pillows. The parents reported the child was able to roll from her back to her stomach. Law enforcement did not believe at the time that there were any indications of abuse or neglect. The family had been living in Kitsap County for approximately one month prior to the death of this child. The family previously lived in eastern Washington.

Referral History

On November 1, 2005, a doctor treating the deceased child's mother called Child Protective Services (CPS) intake to report concerns. The mother was 12 weeks pregnant and the doctor observed multiple bruises all over the mother's body. The mother repeatedly denied any physical or emotional abuse. This referral was screened as information only.

On January 1, 2008, CPS intake received an anonymous referral alleging the deceased child's parents left her and her older brother, then ages three months and 19 months, home alone for three hours. The parents gave a baby monitor to an intoxicated neighbor to monitor the children. The deceased child's parents returned at 3 a.m. The referrer insisted there was something wrong with the three-month-old. She appeared to shake constantly and seemed very thin. The referrer alleged this infant was not fed by her mother on a regular basis. The infant (the deceased child) vomited constantly. The referrer did not believe the mother sought medical attention for the baby. The referrer reported the infant was left in her car seat and cried herself to sleep. She was put in a darkened bedroom, in her car seat, for up to three hours, crying and screaming. The anonymous referrer also reported the house was full of cigarette butts and pop cans. The house was extremely cluttered with drug paraphernalia around. The referrer reported the deceased child's father was a drug user and was just out of prison for burglary. This referral was accepted for investigation for CPS. The social worker found the home clean

and no sign of drug activity or alcohol consumption. The mother took the infant to the doctor for a well child check. The doctor reported the child was not malnourished and her weight gain was within normal limits. This referral was closed with an unfounded finding.

On January 17, 2008, a relative called CPS intake to report the deceased child, then four-months-old, was malnourished and shook constantly. The referrer believed the shaking was drug related. The referrer stated the child was born with a low birth weight and was failing to thrive. The referrer said the mother smoked marijuana all the time and did so throughout her pregnancy. The mother was also alleged to use morphine, crank and methamphetamine. The case was still open from the previous referral. The parents were fairly uncooperative with the social worker and would cooperate only when law enforcement was involved. The deceased child was seen by a doctor who determined she was gaining weight appropriately. This referral was closed with an unfounded finding.

Issues and Recommendations

Issue: Specific individuals were identified in the CPS investigation as possibly having more information regarding the allegation reported on January 1, 2008. The social worker did not contact those two individuals during the investigation.

Recommendation: Investigators should collect information and evidence from collateral and witness interviews.

Issue: The record does not reflect any shared decision making process prior to the case closure of the January 2008 referrals, including supervisory review.

Recommendation: Shared decision making occur prior to case closure or, at a minimum, at the supervisory review.